**OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT**
**HEALTHCARE INFORMATION DIVISION**
**PATIENT DISCHARGE DATA SECTION**
818 K Street, Room 100
Sacramento, California 95814
(916) 323-7679 FAX (916) 327-1262

# Agent Designation Form

Facilities must complete this form in order to designate a third party agent to submit data on their behalf. All information must be provided, including a signature from a facility administrator or primary contact.

***Please print clearly***

## Section 1: Facility Information *(all information is required)*

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|---|---|
| 1. **FACILITY NUMBER :** | 2. **FACILITY NAME:** |
| 3. **FACILITY BUSINESS ADDRESS (MAILING ADDRESS):** | |
| 4. **FACILITY CONTACT NAME:** | 5. **TITLE:** |
| 6. **PHONE:** | 7. **E-MAIL ADDRESS:** |

## Section 2: Designated Agent Information *(all information is required)*

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|---|---|
| 8. **NAME OF DESIGNATED AGENT (COMPANY NAME):** | |
| 9. **BUSINESS ADDRESS (MAILING ADDRESS):** | |
| 10. **CONTACT NAME:** | |
| 11. **PHONE:** | 12. **E-MAIL ADDRESS:** |
| **DESIGNATION EFFECTIVE DATE** | |
| 13. **EFFECTIVE BEGIN DATE:** | **Designation is effective until OSHPD receives written notification of revocation or new designation.** |

By signing this document, I certify that I am an official of my facility and that I am approving the aforementioned Designated Agent to submit data on behalf of my facility for the designated effective dates.

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|---|---|
| 14. **NAME (PRINT):** | 15. **TITLE:** |
| 16. **SIGNATURE:** | 17. **DATE:** |